Community Mental Health Services Block Grant Plan and Application

Adult & Children and Youth Services

July 1, 2004 – June 30, 2005

PART C. STATE PLAN

SECTION I. Description of State Service System

Overview of the Mental Health System

The state system of behavioral health care consists of four major service delivery entities: TennCare and the TennCare Partners Program (TCPP) for medically necessary medical and behavioral health care services; Department of Mental Health and Developmental Disabilities (DMHDD) contract services for education, prevention, early intervention, support, recovery, and model program development; Department of Health (DOH), Bureau of Alcohol and Drug Abuse Services (BADAS), for education, prevention, and non-TennCare covered substance abuse treatment services and the Department of Children's Services (DCS) for services to children in or at risk of state custody.

Since July 1, 1996, Tennessee's public health system has operated under a Medicaid waiver managed care program. TennCare provides medical services through Managed Care Organizations (MCO), and the TCPP provides behavioral health care services through Behavioral Health Care Organizations (BHO). During FY03, there were over 1.6 million individuals eligible to receive services for some period of time, regardless of the length of the eligibility period. TennCare provides services to persons with Medicaid and other non-Medicaid eligible individuals meeting specific criteria as uninsured or uninsurable. TennCare, a responsibility of the DOH, Bureau of TennCare, is administratively responsible to the Department of Finance and Administration (DFA).

DMHDD administers five state operated psychiatric hospitals, referred to as Regional Mental Health Institutes (RMHI), and contracts with private, non-profit community mental health centers and other organizations to provide a variety of non-TennCare covered services in the areas of education, early intervention, prevention, housing, co-occurrence, criminal justice, suicide prevention, recovery and support.

FY04 Areas for Attention and Accomplishments

- Title 33 Revisions: DMHDD held public rulemaking hearings on four chapters of rules, one of which became effective in FY04. The Department repealed five chapters of rules on alcohol and drug services and drafted twelve chapters of rules, three of which completed the review cycle and became effective in FY04. Mandatory outpatient treatment forms and a manual were completed. The forms and manual are on the DMHDD web site.

- Housing Expansion: DMHDD's Creative Housing Initiative (CHI) continues to expand with the development of 271 additional housing units and vouchers for existing housing. Some $10,500,000 was leveraged for housing development. Units acquired range along a continuum from home ownership to supervised group housing.

  CHI launched a Housing Within Reach website during FY04 that allows stakeholders to research housing options, locations, and availability across the state. (www.housingwithinreach.org).

- Cultural Competency: An update of the Strategic Plan for Cultural Competence was completed by July 2004. Members represent the Muslim faith, the Hispanic/Latino community, "New American" status, the deaf community, the African American community and the Chinese Asian community. Seminars were held by representatives from Somalia, Iraq, and Vietnam to share cultural information about mental health issues. Several cultural resource guides were reviewed for use by providers and a mental health curriculum for interpreters was developed. Training in interpreter use was conducted in all regions of the state.

- Co-Occurrence Infrastructure: DMHDD made application for a Co-occurrence State Incentive Grant (COSIG) for treatment of persons with co-occurring substance related and mental disorders in FY04, but Tennessee was not chosen as one of the recipient states. The committee that was formed to work on the grant proposal continues to meet and will go forward with recommended task force goals, as financially able to do so.

  Additional funding was put in place to provide case management services for adults with co-occurring disorders. Funding for an east Tennessee elementary and middle school education curriculum on co-occurring disorders was increased along with a request for outcome measures and evaluation of the process. One assertive community treatment team dedicated to serving adults with co-occurring disorders was discontinued at the end of FY04 due to a contractual disagreement.

- Telemedicine: Clinical program guidelines were developed for telepsychiatry. The BHO has been encouraged to enhance the utilization of telemedicine, especially in rural areas. The BHOs issued a mini request for proposals with a focus on maximizing children's evaluation, medication management, and outpatient services through the purchase of hardware and phone lines for telemedicine capability. Currently, telemedicine services for pre-hospitalization assessment, medication management, and consultation exist in thirty-five counties.

New Developments and Issues

In May 2004, Tennessee's Governor was successful in getting a TennCare reform bill passed by the legislature in an effort to decrease escalating costs. The benefit plan limits the number of prescriptions, doctor visits, and other medical care and charges co-payments of $1 to $40 for many enrollees. Advocates are voicing concerns. Among them, whether persons requiring more than the six prescriptions a month limit will be exempt from the limit rule; how TennCare will define who is disabled and thus exempt from most limits; and whether people have to change medications under rules that say enrollees must use the lowest-cost, effective drug available.

The changes could begin as early as January 1, 2005 depending on federal approval from the Centers for Medicare and Medicaid Services (CMS). Failure to obtain approval for the changes might result in a return to traditional Medicaid and loss of insurance coverage for many non-Medicaid eligible individuals currently receiving managed care services.

Legislative Initiatives and Changes

In addition to TennCare Reform, several other pieces of legislation successfully passed during the 2004 session that provide for the following:

- Permit judicial proceedings held under mental health statutes to be conducted by televideo. This is intended to be less traumatic for consumers and a less costly process for hospitals while not compromising consumer rights.
- Delete the requirement for a Certificate of Need (CON) from the Health Services Development Agency to establish a residential treatment facility. The difficulties of the CON process have been such that it suppressed the development of new facilities. Facilities that would otherwise qualify for this category were licensed as childcare agencies by DCS and as a day treatment facility by DMHDD. This did not support optimum mental health treatment.
- Authorize establishment of a mental health court in Shelby County, Memphis.
- DMHDD and other agencies will study the feasibility of a guardianship program for persons with mental or physical disability.

Regional / Sub-state Program Description

There are currently nineteen private, non-profit Community Mental Health Agencies (CMHA) providing services in the Tennessee system in over 110 satellite locations across the state. The majority of agencies are meeting needs with available resources and negotiate with the BHOs for additional service initiatives. The BHOs contract with each of the traditional community mental health center providers and the five RMHIs as well as a number of other private and non-profit community mental health providers.

Most agencies receive other support through the United Way, fund-raising activities, Employee Assistance Programs (EAP), and other local, county, and state grants. However, due to decreasing private insurance coverage for behavioral health services, the percentage of Medicaid (TennCare) dollars is increasingly a larger portion of agency funding.

DMHDD contracts with sixteen CMHCs and twenty-three other agencies and organizations to provide services supplemental and complementary to medically necessary services provided under TennCare as well as other service initiatives.

State Mental Health Agency Leadership

A commissioner heads the State Mental Health Authority. The Commissioner of DMHDD is a cabinet-level position and, as such, has direct access to the Governor.

DMHDD contracts with the BHOs for services under the behavioral managed care program. The Office of Managed Care (OMC) within DMHDD oversees contracting for the TCPP and works closely with the Bureau of TennCare on priority population definition and classification, contract language, enrollment criteria, marketing and educational material development, best practices, data collection and reporting, and adequacy of provider networks.

DMHDD staff provide advocacy, planning, service development, program monitoring and evaluation, budget monitoring, and technical assistance for non-TennCare community support programs and forensic services.

DMHDD maintains mental health licensing responsibilities, oversight of the forensic services contract for adults and juveniles and PASRR (Preadmission Screening and Resident Review) activities for those persons applying for nursing home admission and thought to have a mental illness. In addition, DMHDD is responsible for investigations at RMHIs and complaint resolution for consumers, family members, legislators, and the public. The Department also oversees a number of federal grants that provide for initiatives in the areas of criminal justice, homelessness, systems of care, housing, and all-hazards planning and response.

The Department identifies, advocates, and plans for adults with SMI and children and youth (C&Y) with SED. Our focus is on integration of multi-agency funded services to provide appropriate service components that are designed to meet behavioral health needs along a continuum from education and prevention to rehabilitation and recovery.

VISION: People with mental illness, serious emotional disturbance, or developmental disability have a quality life based on their individual needs and choices.

MISSION: The mission of the DMHDD is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports.

As of July 1, 2004, the DMHDD experienced extensive reorganization. A revised departmental organization chart is on page 33.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

a) ADULT MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community-Based Mental Health Service System

Approximately 126,251 adults received behavioral health services through the TCPP in FY03; a 5% increase over FY02. (URS Table 2A) Over 46,000 adults with SMI benefited from support and recovery services provided outside of the managed care system. The medical and behavioral benefits offered under TennCare, combined with the support, recovery and special population initiatives provided with state and Block Grant dollars, serve to provide a comprehensive array of community services.

Race and ethnicity percentages served are generally comparable with the 2000 census, although regional differences are not reflected in the aggregate data. Services to adults identifying themselves as Hispanic decreased by 7% between FY02 and FY03. This decrease may reflect differences in self identification, be an indication of the increase in non-traditional Hispanic services options, or reflect a reluctance of this population to access traditional services. FY04 data will be examined to determine whether there is a downward trend in service delivery to this population.

Approximately 3.5% of adults receiving services in both FY02 and FY03 were age 65 and over, well below the 2000 census estimate of 12% in the state. Many seniors are reluctant to access services through traditional mental health clinics and may be receiving behavioral health services through primary care physicians or public clinics. DMHDD funds four programs across the state targeted to older adults. These programs collaborate with the older adult services community to provide outreach, assessment, and in-home peer and professional counseling services.

There was a nearly 26% increase in adults served in psychiatric hospitals between FY02 and FY03; a 31% increase at RMHIs and a 25% increase at other psychiatric hospitals. (URS Table 3B) Tennessee continues to struggle with increased admissions to inpatient treatment. Alternatives will become critical with the removal of the Institutes for Mental Diseases (IMD) exception for Medicaid funding for adults.

In FY03, over 86% of adults responding to the adult consumer survey reported positively about access. (URS Table 11)

Criterion 2: Mental Health System Data Epidemiology

Approximately 72% of adults estimated to have SMI, based on the prevalence rate in URS Table 1, were enrolled in the TennCare Program during FY03, either through Medicaid eligibility or as uninsured or uninsurable. The penetration rate has climbed steadily since 1998. Seventy percent (70%) of adults receiving services were assessed as SMI. (URS Table 14A) Procedures to enroll uninsured individuals with a mental illness requiring treatment as "state-only" recipients allow for immediate service provision until benefit eligibility can be determined.

Criterion 3: Children's Services – Not Applicable to Adult Plan

Criterion 4: Targeted Services to Rural and Homeless Populations

The state is currently unable to report on individuals served by homeless status within the managed care population. (URS Table 3A) Past estimates of the number of homeless adults with mental illness in the state have ranged from 8,500 to 9,000 adults. DMHDD is dependent upon federal support from the Projects for Assistance in Transition from Homelessness (PATH) to provide outreach and case management services to homeless adults. PATH projects in FY03 outreached to some 1,600 adults. Since FY99, PATH has expanded from the four original urban programs to a total of ten projects, five of them serving smaller cities and rural counties. Ongoing challenges for services to this population include housing options, funding for psychotropic medication and transportation, and access to behavioral health services.

The percent of rural TennCare Partners enrollees and numbers served continue to be consistent.

Criterion 5: Management Systems

Many state agencies have undergone annual decreases in budget over the past three years. DMHDD was spared these reductions due to the advocacy of its Commissioners and various consumer and family groups. A minor decrease in Block Grant funding necessitated some shifting of contract dollars, but no reduction in total funding.

The number of mental health staff at Central Office has decreased somewhat, with several staff shifted to mental retardation services. A recent reorganization of DMHDD consolidates services under a core group of executive staff and is hoped to result in a more equitable distribution of job responsibilities. The state psychiatric institutes continue to have difficulties with recruitment and retention of qualified nursing staff, psychiatrists, and pharmacists. Base salary increases have resulted in short-term staffing gains, but salary levels are unable to stay competitive with community positions over time.

DMHDD increased its training to emergency personnel and first responders during FY04 and is partnering with the DOH to provide training in all-hazards behavioral response as part of state bioterrorism planning. Training opportunities for contract agency staff are provided by the MCOs and BHOs.

Strengths and Weaknesses of the System

Tennessee's current system of managed care provides coverage to many citizens who otherwise would not have access to health insurance. Approximately 25% of TennCare members do not qualify for Medicaid. A "state-only" eligibility provides a safety net for individuals with SMI requiring mental health treatment who are ineligible or have not yet applied for coverage. The provision of clinical treatment services under managed care allows DMHDD to contract federal Block Grant and state dollars toward services that promote recovery and resiliency in adults with SMI.

Strengths of the current system of care for adults include: the wide availability of assertive community treatment; consumer-run education, support and recovery services; the criminal justice liaison project; an open formulary; clinical staff qualifications; integrated service initiatives and housing initiatives.

A DMHDD Leadership Team process identified four barriers to effective behavioral health services: a lack of agency coordination to promote prevention, early intervention and recovery; a lack of services and supports at a level of care that supports rehabilitation along with other treatment; insufficient human resource capacity and points of access; and insufficient or poorly allocated financial resources.

Analysis of Unmet Service Needs and Critical Gaps

The service gaps documented in the annual needs assessment conducted by the seven Regional Mental Health Planning and Policy Councils (RMHPC) were prioritized into statewide initiatives that reflected the most documented service need areas across the state. For adults, these include alternatives to hospitalization (crisis stabilization, respite and step-down services); expansion to statewide availability of services for consumers interfacing with the criminal justice system; and recovery-oriented services that promote community reintegration (consumer-run services, transportation, employment and housing).

Statement of State Priorities and Plans to Address Unmet Needs

A complete review of DMHDD funded services was accomplished in March 2004. Services were ranked in three ways: 1) in how many regions was the service available; 2) did the service target priority populations; and 3) was the service an evidenced-based practice or have a data-based effectiveness history. Further, a service was identified for further discussion if it was failing to accomplish goals, meet service level expectations, or might survive with decreased funding. Discussion then focused on what existing programs might need increased funding to operate most effectively, where programs were failing, and what new initiatives might be recommended. Attention was paid to geographical distribution, nationally recognized programs, and initiatives that might assist in meeting goals of the President's New Freedom Commission on Mental Health.

Service needs identified and prioritized in the annual council needs assessment process will be recommended for inclusion in the annual budget request to the legislature. Region-specific requests are being reviewed for funding as dollars become available or alternate grant resources are identified. The Leadership Team process has identified a three-level mental health prevention model for service development and delivery: 1) Primary (targeted prevention efforts); 2) Secondary (post-diagnosis prevention of long term disability through early and adequate interventions); and 3) Tertiary (preventing severe impairment from becoming debilitating to role function through support and rehabilitation services).

Summary of Significant Achievements Reflecting Progress Towards the Development of a Comprehensive Community-based Mental Health System of Care

A number of achievements reflect development of a more comprehensive system of care for adults. Over 200 providers were added to the BHO outpatient provider network; crisis respite beds were expanded by 22% with increased utilization. Services to homeless adults with SMI have been expanded. Criminal justice mental health liaison projects have expanded to cover an additional three counties.

DMHDD reorganization brings support, employment, transportation, and housing (SETH) service initiatives under one Office of Recovery Services (ORS). In light of the extreme success of the CHI initiative for housing, the Creating Jobs Initiative was announced in August 2004 to work within communities across the state to develop and expand employment opportunities for individuals with SMI and with co-occurring disorders (COD) of mental illness and substance abuse. The seven regional housing coordinators have been renamed regional SETH facilitators to reflect the broader scope of the ORS.

Brief Description of the Public Mental Health System Envisioned for the Future

In February 2003, the Commissioner of DMHDD established a Leadership Team charged with reviewing the way mental health services are delivered in the state, determining what is working and what is not working, and recommending methods to improve service delivery. Workgroups focused on one of four key areas: Access and Capacity, Funding, Services and Supports, and Integration.

The Leadership Team initially conducted meetings with a variety of stakeholders in each of the three grand divisions of the state: east, middle and west. Follow-up meetings were conducted with each of the seven RMHPCs and the TennCare Partners Roundtable (TCPR). Input was provided and reviewed by the SMHPC and goals were developed. Tennessee's Vision for a New System declares:

The public mental health system will serve the best interest of all Tennesseans to achieve:

- Improved Wellbeing/Protection/Safety
- Improved Quality of Life
- Enhanced Health of the Whole Public

By

- Providing care for those with the greatest need that cannot be met otherwise, and
- Setting the overall framework for all mental health care.

Goals for the future system include:

- Adequate funding to meet the needs and provide quality care.
- Services that emphasize prevention, treatment and recovery.
- Continuity of care regardless of who provides or pays.
- Interagency and intersystem cooperation to promote holistic care.
- Maximum consumer/family reintegration.
- Consumers and providers work as partners to plan treatment and achieve outcomes (active participant vs. passive recipient).
- Shared accountability by elected officials with DMHDD as focal point for the public system.
- Maximize funding in a manner that promotes public policy goals for prevention, treatment and recovery.
- Promotion of mental/emotional wellness.
- A complete array of services that meets individual needs, can be accessed in a timely manner, and is sufficient to prevent or ameliorate disability.

Five service models were reviewed to determine which model or combination of models can best meet the goals of the future service system. The final report with vision, goals and suggested structure was reported to the SMHPC in May and the Departmental Planning and Policy Council (DPPC) in June 2004. Targeted operational date is 2005.

The Commissioner of the DMHDD has targeted a "recovery" model approach throughout all service areas under authority of the Department.

DMHDD's strategic plan lists the following prioritized goals:

1. By 2009, the public's knowledge and understanding of mental illness and its effective treatments will increase.

2. By 2009, mental health service providers' understanding of the prevalence of and best practice treatments for co-occurring disorders will increase.

3. By 2009, DMHDD will increase funding sources for a continuum of recovery services to better meet the needs of Tennesseans with mental illness.

4. By 2009, DMHDD will standardize the treatment of mental disorders in the five RMHIs.

5. By 2009, the number of licensed mental health professionals (psychiatrists, nurses, social workers and psychologists) working in Tennessee's public sector will increase.

The Department is working to increase the mental health services provided in the state. Currently, DMHDD is reviewing the mental health services system with the goal of presenting a plan to the Governor in the near future for a new service model to improve mental health services delivery, including how providers are compensated.

b) CHILDREN'S MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community-Based Mental Health Service System

Approximately 45,541 children and youth below the age of eighteen received behavioral health services through the TennCare Partners Program in FY03; a 7% increase over FY02. (URS Table 2A)

Some 136,300 children and youth and over 6,000 family members and other adults benefited from a variety of services provided outside of the managed care system. The medical and behavioral benefits offered under TennCare and TennCare Partners, combined with the early intervention, prevention, education and support services provided with state and Block Grant dollars, serve to provide a comprehensive array of community services.

Race and ethnicity percentages served are generally comparable with the 2000 census, although regional differences are not reflected in the aggregate data. The number of children served and identified as Hispanic remained consistent for FY02 and FY03, but well under the census population estimates. In FY03, some 86% of families reported positively on participation in treatment planning for their children. (URS Table 11)

Age breakout for FY02 and FY03 remained the same; approximately 55% of children between the ages of four and twelve and 43% between the ages of thirteen and seventeen.

There was an 11% increase in children and youth served in psychiatric hospitals between FY02 and FY03; an 8% increase at RMHIs and a 12% increase at other psychiatric hospitals. (URS Table 3B) The specialized crisis services program for children put in place in March 2004 is expected to decrease children and youth inpatient utilization.

In FY03, nearly 80% of returned child and adolescent consumer surveys reported positively about access. (URS Table 11)

Criterion 2: Mental Health System Data Epidemiology

Approximately 67% of the under eighteen population estimated to have a Serious Emotional Disturbance (SED), based on estimates given in the Federal Register, were enrolled in the TennCare Program during FY03. The penetration rate has climbed steadily since 1998. Fifty-eight percent (58%) of children and youth receiving services were assessed as SED. (URS Table 14A) Procedures to enroll uninsured children and youth with SED requiring treatment as "state-only" recipients allow for immediate service provision until benefit eligibility can be determined.

Criterion 3: Children's Services

Given the various Departments involved in services to children; e.g. DCS for children in custody, Education for schools, Health for TennCare services and Mental Health for behavioral health care, it is necessary for careful attention to integration of effort. By Executive Order, the Governor's Children's Cabinet was established in March 2003 to coordinate and streamline services to children.

The Commissioner of each child-serving department, child advocate organizations and citizens with a strong commitment to and understanding of the challenges and issues affecting Tennessee's children served as members. In June 2004, the Governor announced the establishment of the Governor's Office of Children's Care to ensure that the delivery of services to children is effective, efficient and coordinated. Initial efforts will be targeted toward the delivery of health care.

TennCare policy is targeted to broaden eligibility to all children of low-income families without insurance coverage. Early, Periodic Screening Diagnosis and Treatment (EPSDT) activities have been increased. In the arena of mental health, Tennessee is able to utilize state and Block Grant dollars to provide a variety of early identification, intervention, prevention, and family support services not always seen in other states.

Criterion 4: Targeted Services to Rural and Homeless Populations

The state is currently unable to report on individuals served by homeless status within the managed care population. (URS Table 3A) Estimates of the number of homeless families with children ranges from 4,000 to 4,500. School system data shows a gradual increase each year of homeless children attending school. Six outreach programs for homeless families of children with SED or at risk of SED served 488 families and 1,085 children during FY03. This is a strong program and one of the few of its kind for children who are living in homeless families.

Approximately 44% of children with SED enrolled in TennCare reside in a rural county. This percentage has remained stable over several years as has the percentage of rural enrollees served. A majority of the FY04 BHO expansion allocations, described under Significant Achievements on page 41, were dedicated to services in rural counties.

Criterion 5: Management Systems (Also see Adult Section, page 35)

Specific to services for children, there is continuing need for increased clinical staff with specialization in this area, especially outside of the larger cities. The BHO expansion funding for children's services included nine grants for clinical staff positions at various agency locations across the state.

Strengths and Weaknesses of the System (Also see Adult Section, page 35)

Strengths of the current system of care for children and youth include: targeted prevention and early intervention activities for pre-school and school-age children, expansion of the system of care grant program, planned respite services, family homeless outreach, anti-stigma educational efforts, and service programs for targeted special populations. Weaknesses cited are a lack of in-home service options and an array of transitional services for youth age 16-21.

Analysis of Unmet Service Needs and Critical Gaps (Also see Adult Section, page 36) The service gaps documented in the annual needs assessment conducted by the seven regional councils were prioritized into statewide initiatives that reflected the most documented service need areas across the state. For children and youth, these include a continuum of school-based care (preschool through college); programs for transitional age youth (leaving state custody, moving to adult services, or needing to develop independent living skills); and mental health liaison projects for children and youth interfacing with the juvenile justice system.

Statement of State Priorities and Plans to Address Unmet Needs

Service needs identified and prioritized in the annual council needs assessment process will be recommended for inclusion in the annual budget request to the legislature. Region-specific requests are being reviewed for funding as dollars become available or alternate grant resources are identified.

An Interagency Workgroup met for three months during FY04 to develop a strategy for youths in transition from the child to the adult service system. A Transitional Needs Rating Assessment form was developed that could be used by all agencies to score the level of need for youth when engaging in transitional planning. The workgroups position paper and assessment form will be reviewed by all participating agency heads and, if approved, will be presented to the Governor's Children's Cabinet and Office of Children's Care for further action.

The Leadership Team process has identified a three-level mental health prevention model for service development and delivery: 1) Primary (targeted prevention efforts); 2) Secondary (post-diagnosis prevention of long term disability through early and adequate interventions); and 3) Tertiary (preventing severe impairment from becoming debilitating to role function through support and rehabilitation services).

Summary of Significant Achievements Reflecting Progress Towards the Development of a Comprehensive Community-based Mental Health System of Care

A number of achievements reflect development of a more comprehensive system of care for children and youth. Twenty new contracts and grants were awarded to providers to address children's needs in the areas of substance abuse, sexual offender treatment and dual diagnosis of SED and mental retardation. Specialized children's crisis services diverted 75% of children seen from inpatient care and the Comprehensive Child and Family Treatment team census doubled to 400 children.

During FY04, DMHDD, in conjunction with the BHOs, implemented proposals from providers statewide for the purpose of expanding and enhancing children's services. These included six telemedicine grants, nine grants for additional child psychiatrist and nurse practitioner time, four grants for school-based services, and three grants for mental health service staff at primary care physician offices.

Brief Description of the Public Mental Health System Envisioned for the Future

(Also see Adult Section, page 37). One of the major goals for children's services is making a system of care approach a reality in Tennessee, one community at a time. Service outcomes have shown decreased out of home placement, increased family stability, clinical and school improvement, and better coordinated services between agencies. A partnership has been developed for the system of care project to assist DCS in the successful transition of children out of state custody and back into the community. Several state child-serving departments and state child advocacy groups are working with the Governor's Children's Cabinet and Office of Children's Care to educate and plan toward a statewide system of care emphasis for children's services.

SECTION III. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

a) ADULT PLAN

1) Current Activities

i. Criterion 1 A Comprehensive Community-Based System of Care

Mental Health Services: Currently, the TennCare benefits package includes the following services. Adults with SMI are exempt from benefit limitations.

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient, Residential and Outpatient Substance Abuse Treatment Services
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Psychiatric Rehabilitation Services
- 24/7 Crisis Response Services and Crisis Respite

In addition to the TennCare medical and behavioral health benefit package, the following services are available within the comprehensive array of community services:

Employment Services: Vocational programs are available at eighteen Psychosocial Rehabilitation Service programs across the state. Services may include, but are not limited to, supported employment, pre-vocational work units, vocational work assessments, job readiness training, and work enclaves. Employment services are also available directly from the Department of Human Services, Division of Vocational Rehabilitation. The Creating Jobs Initiative begun by the DMHDD Office of Recovery Services is expected to increase employment opportunities substantially over the next five years.

Rehabilitation Services: For individuals not able to or desiring to work, psychosocial programs and Drop-in Centers provide skill building, promote independent living capabilities, and offer educational and social rehabilitation opportunities.

Housing Services: DMHDD supports forty agency-operated HUD group homes and supported living apartments, six assisted living sites and provides supplemental funding for utility and rent to assist consumers with SMI to maintain housing of their choice. Tennessee's Creating Homes Initiative develops housing options and assists adults with SMI in finding appropriate housing for their needs.

Educational Services: GED classes and other educational activities are available at Psychosocial Rehabilitation programs and at many of the fifty Drop-in Centers across the state. Adults, aged 18-22, who are still attending school may also be served under the Individuals with Disability Education Act by the Department of Education.

Medical and Dental Services: Primary care physician and specialist medical services are provided under TennCare. Two Mental Health/Primary Care Integration Projects provide an integrated model of assessment and treatment. A portion of independent living assistance funds are available to community providers to access needed medical and/or dental care for priority population adults.

Substance Abuse Services: Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of the BHOs and the DOH, BADAS. Many of these contract agencies are CMHAs.

Case Management Services: Mental health case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. Mental Health Case Management Services are an available benefit of the TennCare Partners Program. As of July 2004, members will be assessed for level one and level two case management services regardless of priority population status. The assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. The BHOs have documented policies regarding all level one and level two case management caseload capacities and expected consumer outcomes.

Case management services for adults include the more intensive Continuous Treatment Teams, one Program for Assertive Community Treatment (PACT) team, and one Forensic Assertive Community Treatment (FACT) team.

Services for Co-occurring Disorders (COD): The Co-occurrence Project, a joint effort of DMHDD and the DOH, BADAS, supports a statewide resource center, dual recovery self-help groups, limited case management for those without TennCare, vocational services and provider education. There are currently two continuous treatment teams for adults with COD operating under the TCCP.

DMHDD funds Foundations Associates to promote and develop integrated services for adults with COD at agencies across the state. The grant also supports a transitional housing program and the Dual Diagnosis Recovery Network (DDRN) which promotes addiction education and develops Dual Recovery Anonymous support groups statewide. While not exclusively for consumers with COD, Foundations supports a Drop-in Center (DIC) and provides independent living subsidies

Services for Special Populations: DMHDD supports the following service initiatives for those with special needs:

- Services for Older Adults: Four projects offer outreach professional mental health counseling and other support services to adults age fifty-five and over who are homebound or do not access traditional outpatient mental health services. In addition, a CMHS grant supports the initiation of statewide mental health aging coalitions.

DMHDD contracts for and oversees the PASRR process for individuals in nursing homes or seeking nursing home admission. Between FY02 and FY03, there was a slight increase in the number of preadmission screenings and a slight decrease in the number of annual resident reviews.

- Services for Consumers Interfacing with Criminal Justice System: Criminal Justice liaison staff provide early identification of persons with SMI or COD within the criminal justice system, promote diversion alternatives to community programs, and provide training and education to enhance collaborative efforts between the criminal justice and mental health systems. Currently, there are nineteen criminal justice projects covering twenty-four counties.

- Deaf and Hard of Hearing: This population is included in cultural competence efforts and DMHDD staff attend meetings of the Tennessee Council for the Deaf and Hard of Hearing. All mental health planning council meeting announcements contain special accommodations information and interpreters are provided as needed. The BHOs require contract providers to assure interpreters as needed.

Activities to Reduce Hospitalization:

- 24-Hour Walk-in Assessment and Triage, Knoxville and Nashville: Crisis service staff are on site and provide evaluation, medication, and counseling services for up to eight hours.

- Crisis Stabilization Unit, Chattanooga: Serves medically stable adults who present in a psychiatric crisis and are assessed as needing a level of care greater than respite but less than inpatient psychiatric hospitalization.

- Targeted Transitional Support: Assists persons eligible for discharge from the RMHIs to move to community settings with temporary transitional support until their financial benefits/resources are established.

- Mandatory Prescreening Law: A pre-screening evaluation for eligibility for emergency involuntary admission to RMHIs. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis.

- Mobile Crisis Response Services: Crisis response services are available 24/7 in every county in Tennessee. Approximately 48% of adult face-to-face contacts result in diversion from an inpatient setting.

Other Support Services: DMHDD assists in funding the following support services:

- Twenty-six consumer support groups across the State, including the consumer-taught education group, BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support).

- Thirty-four family support groups through NAMI-TN family members of persons with psychiatric disorders, including the development of Journey of Hope (JOH) educational classes for relatives of individuals with a mental illness.

- A statewide suicide prevention hotline, survivor support groups, and staff training in suicide prevention.
- Fifty consumer-run Drop in Centers providing recovery directed opportunities targeted toward illness management and community reintegration.

All services under Criterion 1 have been implemented. The Commissioner's focus on all services recognizing and working toward recovery is expected to increase the focus of provider training on recovery and ensure the development of outcome measures to indicate consumer movement toward their goals.

ii. Criterion 2 Mental Health System Data Epidemiology

DMHDD provides an annual table of prevalence and penetration. The population and prevalence estimate is from URS Table 1 received from CMHS. The annual penetration rate is defined as being enrolled in TennCare Partners as a priority population adult for any period of time during the fiscal year.

TABLE 2.01 ESTIMATED # OF PRIORITY POPULATION AND TENNCARE ENROLLMENT

2003 TN Population (18 and over)	Estimated % SMI	Total SMI	SMI TennCare Enrolled FY04 ①	Penetration Rate
4,447,269	5.4%	240,153	175,172	73%

① Individuals with a CRG assessment code of 1, 2, or 3 (SMI/SPMI) enrolled in TennCare for any period of time during July 2003 through June 2004. Source: Research and Analysis, Office of Managed Care, DMHDD, August 2004.

Tennessee utilizes the federal definition for its adult priority population: "An individual age eighteen and over who currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual that has resulted in functional impairment that substantially interferes with or limits one or more major life activities." The degree of functional impairment is assessed by way of a Clinically Related Groups (CRG) assessment form. Those in categories CRG 1, 2, and 3 are considered either SMI or SPMI, based on duration and severity.

During FY05, DMHDD Block Grant and state funding is estimated to provide direct support and recovery services to 47,000 adults with SMI.

Further quantitative goals for FY05 are included in the Adult Goals, Targets, and Action Plan section for Criterion 2 on page 57.

iii. Criterion 3 (Not applicable to Adult Plan)

iv. Criterion 4 Targeted Services to Rural and Homeless Populations

Rural

The U.S. Census Bureau's current definition language for rural is "all territory, population, and housing units located outside of urbanized areas and urban clusters". For purposes of defining rural counties, we will define a "rural county" as one that has 50% or more of its population in a rural area and is not included in the Metropolitan Statistical Areas county list. This information is obtained from the 2003 Tennessee Statistical Abstract.

Using the above definition, the number of defined "rural" counties in Tennessee would drop from seventy-seven to fifty-nine.

The TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations. Non-clinical service initiatives like Drop-in Centers and consumer support groups are located in rural areas with transportation provided for access.

A critical issue for rural residents is their ability to access available services, especially medical health specialists. Several rural-based CMHAs participate in the federal rural recruitment and retention plan to hire psychiatrists and psychologists.

Rural service planning must also take into account the routine travel patterns of rural populations for other services (e.g., shopping, banking, recreational, etc.) to provide convenient access to behavioral health services.

Homeless

The TCPP provides a continuum of services for all eligible individuals with SMI. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes. Homeless persons who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost consumer and family support groups and Drop-in Centers at various locations throughout the state.

Over 300 organizations statewide describe themselves as providing a service to some segment of the homeless population. However, only a small number of these have as their primary purpose the provision of services to individuals who are homeless and also have a mental illness.

DMHDD is dependent upon federal support from the Projects for Assistance in Transition from Homelessness (PATH) to provide outreach and case management services to homeless adults. PATH projects in FY03 outreached to some 1,600 adults. Since FY99, PATH has expanded from the four original urban programs to a total of ten projects, five of them serving smaller cities and rural counties.

In addition to the PATH program, there are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. The sites are located in three urban areas: Chattanooga, Nashville, and Knoxville.

Chattanooga has two sites with housing capacity of sixteen adults. Nashville has four sites with housing capacity for fourteen adults. The CHI regional staff work closely with PATH programs to develop housing options for adults with SMI or COD who are also homeless. The state provides supplemental dollars in the amount of $355,500 for PATH and $205,000 for permanent housing.

v. Criterion 5 Management Systems

Financial Resources

Tennessee made available $412,369,500 in capitation payments made monthly to the BHOs for services provided to TennCare Partners Program enrollees through June 30, 2004.

The State continues financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees that it assumed as of July 1, 1999. The pharmacy cost for individuals for FY04 in the community amounted to $616,514,200 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities. This reflects a nearly 58% increase in pharmacy costs over FY03.

The cost of providing forensic and court-ordered evaluations performed at the five RMHIs and in the community is estimated at $24,788,700 dollars.

DMHDD funded community mental health services, excluding forensic and court ordered evaluations, at $23,383,500. This funding includes the CMHS Block Grant award and other federal grants received by the DMHDD. Further, the five RMHIs expended $60,107,300 above revenue received from the two BHOs to provide inpatient mental health services.

In total, roughly $1,137,163,200 was directed for the provision of mental health services to individuals within Tennessee for FY 04 with the goal for this level of funding to be maintained or increased in FY 05.

DMHDD continues to enter into grant agreements to provide mental health service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHAs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

The 2004 CMHS Block Grant award is $8,137,479. Funding in the amount of $7,730,700, 95% of the total award, has been granted to community based programs in accordance with the expectations of the grant. Approximately 5% of the award, or $406,779, supports administrative functions relative to the community mental health system and State Mental Health Planning and Policy Council activities.

Staffing
DMHDD employs approximately 2,900 staff, 178 in Central Office and the remainder in the five state psychiatric hospitals for approximately 950 service recipients.

The state contract with the medical and behavioral health organizations requires those entities to maintain an adequate provider base to provide services to individuals covered under the benefit plan. The BHO's outpatient network consists of around 1,200 credentialed and contracted individual and group providers, exclusive of individual Community Mental Health Center staff.

Additional resources for adults include:
- 22 providers of 24-hour residential treatment at 80 locations
- 29 providers of inpatient psychiatric services at 30 locations
- 22 providers of inpatient substance abuse services at 27 locations
- 21 providers of crisis response services in 95 counties

Training
BHO consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires BHOs to offer the following:
1) an educational plan for providers formulated with input from the BHO Advisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2) cross-training of mental health and substance abuse providers;
3) mental health training for primary care providers; and
4) assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

DMHDD provides routine training for mandatory prescreening agents, mandatory outpatient providers, forensic evaluators, Drop-in Center directors, PATH provider agencies, and criminal justice liaison staff.

In addition to routine networking opportunities and technical assistance, DMHDD sponsors, supports, or provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups, and special grant recipients.

Training Providers of Emergency Health Services
Under the TCPP, mental health staff of crisis response services are in regular contact with providers of emergency health services. Crisis services are funded by the BHOs and are available to emergency health staff twenty-four hours a day, 365 days a year. Crisis staff provide on-going consultation and information on mental health crisis intervention strategies and service alternatives. DMHDD provides training in mandatory pre-screening to eligible mental health professionals.

DMHDD provides for Critical Incident Stress Management training courses in each grand region of the state on an annual basis, including sponsoring scholarships for first responders to attend needed courses through International Critical Incident Stress Management Foundation conferences.

The DMHDD Emergency Services Coordinator provides presentations on all-hazard mental health interventions to local community civic organizations, county CERT (Community Emergency Response Team) volunteers, and community behavioral health staff and other paraprofessionals during times of disaster.

Expenditure of 2005 Block Grant Allocation
DMHDD utilizes its Block Grant funding for the provision of non-clinically related mental health services for adults with SMI and children and youth with, or at risk for, SED. Services are designed to reduce the use of hospitalization; promote education, prevention, and early intervention; integrate services; and build a reliable community support service system that emphasizes empowerment, recovery, and community reintegration for individuals and families.

Currently, fourteen private, not-for-profit CMHCs and five other community agencies receive federal mental health block grant funds to provide services to adults. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.)

Some $5,217,500 of CMHS Block Grant funding will be allocated for adult services in accordance with Criterion 1, 2, 4 and 5 in the following manner:

Assisted Living Housing $ 210,000
Assisted living fills the gap in the continuum of housing available for adults with SMI who do not require the supervision of a Supportive Living Group Home, but do not yet possess the necessary skills for independent living. The programs consist of clustered apartment units, with one unit occupied by a live-in “assisted living specialist”. The specialist is a consumer whose role is to serve as a mentor to and provide support for the other residents. The goal is to assist the consumer in a smooth transition to independent living. Funds support six assisted housing projects.

Criminal Justice Project $ 476,000
Projects provide activities targeted toward individuals with SMI or co-occurring disorders interfacing with the criminal justice system. Services include liaison/case management services, diversion activities, cross-training and education, and appropriate referral and linkage to follow-up services in the community. Goals are to enhance systems collaboration and cooperation, decrease recidivism, and ensure access to appropriate services. Block Grant funds, supplemented by $376,000 in state funding, provide nineteen projects serving twenty-four counties.

BRIDGES Support **$ 226,496**
Funds are provided to the TN Mental Health Consumers Association (TMHCA), via the Tennessee Disability Coalition, to support regional advocacy staff and on-going development of the BRIDGES educational program for mental health consumers.

Cultural Competency **$ 24,200**
Cultural and linguistic competency promotion is targeted for mental health agencies, mental health providers, and mental health interpreters.

Older Adult Project **$ 280,000**
The projects provide professional mental health counseling and peer counseling to adults age fifty-five and over who are homebound or otherwise unable or unwilling to access traditional mental health services. Services may be offered in the individual's home or at a primary care site accessed by older adults. Staff either provide or refer individuals to the appropriate level of mental health services. Services are provided in collaboration between a CMHC and the aging community service system. Funds support four programs.

Drop-in Centers **$ 4,000,804**
Consumer-operated sites provide a non-stigmatizing place to meet other consumers of mental health services. Member planned activities provide opportunities for socialization, personal and educational enhancement, and emotional peer support for adults with serious mental illness. Funds support fifty programs serving eighty-four counties.

It is noted that the final outcome of TennCare reform may impact the allocation of state and Block Grant dollars.

Table 5.02 on page 51 details the proposed 2005 Block Grant contract amounts for adult services by agency and program.

TABLE 5.02 PROPOSED 2005 BLOCK GRANT CONTRACT AMOUNTS FOR ADULT SERVICES

CMHC	Assisted Living	Criminal Justice	BRIDGES / Cultural Competency	Older Adult	Drop-in Center	Total
Frontier	140,000	40,000	0	70,000	462,345	$712,345
Cherokee	0	0	0	0	51,372	$51,372
Ridgeview	0	0	0	0	308,229	$308,229
HR McNabb	0	50,000	0	0	113,191	$163,191
Peninsula	0	0	0	0	154,115	$154,115
Volunteer	0	90,000	0	70,000	986,507	$1,146,507
Fortwood	0	0	0	0	113,191	$113,191
Centerstone	0	105,000	0	70,000	773,976	$948,976
Carey	0	40,000	0	0	308,229	$348,229
Pathways	0	0	0	0	205,486	$205,486
Quinco	0	0	0	0	205,486	$205,486
Professional Counseling	0	0	0	0	205,486	$205,486
Southeast	0	0	0	0	113,191	$113,191
Frayser	0	0	0	70,000	0	$70,000
OTHER AGENCY						
Mental Health Association	0	0	24,200	0	0	$24,200
Mental Health Cooperative	35,000	50,000	0	0	0	$85,000
Park Center	35,000	0	0	0	0	$35,000
Shelby Co. Govt.	0	101,000	0	0	0	$101,000
TN Disability Coalition	0	0	226,496	0	0	$226,496
Total Adult	**$ 210,000**	**$ 476,000**	**$ 250,696**	**$ 280,000**	**$4,000,804**	**$ 5,217,500**
					Total C&Y	$ 2,513,200
					Total Both	**$ 7,730,700**
					Admin. 5%	**$ 406,779**
					TOTAL BG	**$ 8,137,479**

2) Goals, Targets and Action Plans

Criterion 1: Comprehensive, Community-Based System of Care

Goal 1.1. **To assure effective inpatient treatment and continuity of care to maximize community tenure.**

Target: To decrease the rate of readmission to any psychiatric inpatient hospital within 30 days and within 180 days of discharge.

Population: Persons 18 and above receiving a TennCare Partners psychiatric inpatient service during FY04.

Brief Name: **I/P Readmission**

Indicator: Percentage of adults discharged from inpatient services who are readmitted to inpatient care within 30 days and within 180 days.

Measure: % Numerator: Unduplicated # of adults readmitted within 30 and 180 days of discharge.
Denominator: Unduplicated # of adults discharged from psychiatric inpatient care during FY04.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: Readmission is defined as admission to any inpatient psychiatric hospital within 30 or 180 days of a discharge from inpatient stay.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment and the continuity of community care.

Name: **I/P Readmission – (30 days) ①**
Population: **Adults enrolled in the TennCare Partners Program**
Criterion: **1 (Core/State – Developmental Table 21)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	16.5%	16%	16%		
Numerator	4,164				
Denominator	25,287				

Name: **I/P Readmission – (180 days) ①**
Population: **Adults enrolled in the TennCare Partners Program**
Criterion: **1 (State – Developmental Table 21)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	36.2%	36%	36%		
Numerator	9,150				
Denominator	25,287				

① Due to the post fiscal year timeframe for readmission, data reported in FY05 will be for the previous fiscal year.

Data Infrastructure Grant "issues" notes regarding the Uniform Reporting System (URS) tables indicate that the ideal is to expand reporting to include all readmissions to any hospital, not just state hospitals. Since Tennessee has this capacity within its managed care program, Table 21 has been reported rather than Table 20B, readmissions to state hospitals only. Both tables will be reported with the December 1, 2004 submission of the URS data.

The BHOs contract with twenty-nine psychiatric facilities to provide inpatient care to adults. Five of these contracted facilities are state psychiatric hospitals.

Previous studies of reasons for readmission to inpatient treatment found the most prevalent reason to be the discontinuance of medications. Other contributing factors proved to be substance abuse, family disruption, and the diagnosis of a personality disorder.

For those for whom hospitalization is the most appropriate option, successful community tenure is impacted by early discharge planning and the timely availability of less restrictive alternatives. Needs for treatment, housing, case management, support groups, and consumer and family education services must be adequately identified with resources available and accessible upon discharge.

BHO standards of care require case management assessment for individuals being discharged from inpatient care with a case manager face-to-face encounter within seven days and routine outpatient services available within fourteen days. Outpatient providers are required to maintain access logs of initial appointments and performance is monitored by both the BHOs and DMHDD.

A Targeted Transitional Support Program, developed to assist persons attain and maintain discharge from the state psychiatric hospitals, provides temporary transitional support until their financial benefits/resources are established.

Intensive long-term support services were developed in the Chattanooga area designed to maintain discharged service recipients in the community in supportive living facilities. Funds are provided for a wide variety of services and supports that complement existing services funded by various departments of the state (case management, outpatient psychiatric services, mobile crisis services, drop in centers, etc.), which have not sufficiently been able to meet the specialized needs of this population. This intensive and creative project has greatly increased the community tenure of a difficult and vulnerable population.

Goal 1.2: **To provide behavioral health services that are rated positively by service recipients.**

Target: To maintain a rating of 65% of adults who report positively about service outcomes.

Population: Adults receiving services through the TennCare Partners Program during FY05.

Brief Name: **Outcomes**

Indicator: Percentage of adults submitting a positive survey response on outcomes.

Measure: % Numerator: Unduplicated # of adults reporting positive response to survey question on outcomes.
Denominator: Unduplicated # of adults responding to adult survey

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: None

Significance: A client's positive perception of care increases the likelihood of continued service acceptance and positive movement toward recovery.

Name: **Outcomes**
Population: **Adult TennCare Partners Population**
Criterion: **1 (Core – Basic Table 11a)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	64%	65%	65%		
Numerator	929				
Denominator	1,451				

The highest goal of any service system is to attain the best possible outcome for the service recipient. Since FY02, the percentage on the positive outcome measure has ranged from 64% to 66%. These correlate with an 80% rate of participation in treatment planning. It is noted that the stratified sample for FY03 had a 22% response rate.

The BHO system of care has defined outcomes for levels of assertive community treatment and mental health case management services. The Service Planning and Oversight Committee of the SMHPC is advising DMHDD on the development of outcome measures for funded services.

Goal 1.3: **To provide behavioral health interventions for which there are consistent, scientific evidence showing that they improve consumer outcomes.**

Target: To increase by 50 the number of consumers receiving an Evidenced Based Practice (EBP).

Population: Adults assessed as SMI receiving a TennCare Partners service during FY05.

Brief Name: **EBP**

Indicator: Number of adults receiving an evidenced based practice as defined by CMHS.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: State's may be providing other services qualified to be evidenced based practices that are not included in the CMHS table listing.

Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Name: **EBP**
Population: **Adult SMI TennCare Partners Population**
Criterion: **1 (Core – Developmental Tables 16 and 17))**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	4,095	4,000 ①	4050		
Numerator					
Denominator					

① Projection for FY04 decreased due to closure of some adult assertive community treatment teams.

URS Tables 16-17 List the following Evidenced Based Practices:

1. Supported Housing	Yes
2. Supported Employment	Yes
3. Assertive Community Treatment	Yes
4. Therapeutic Foster Care (not applicable to adults)	Yes
5. Family Psychoeducation	Unknown
6. Integrated Treatment for COD	Yes
7. Illness Management and Recovery	Unknown

It is noted that supported housing is currently not broken out from other HUD group homes. Also supported employment can only be tracked by those receiving the service through a psychosocial rehabilitation program. Family psychoeducation, integrated treatment for COD, and illness management and recovery, while undoubtedly practiced in some community mental health settings, are currently not tracked. The FY05 Data Infrastructure Grant activities are targeted to how best to access this information.

In addition to those services listed above, DMHDD also provides wide access for adults with SMI to consumer-run Drop-in Center services, a recognized program for support and recovery.

Goal 1.4: **To maximize the ability to remain in a community setting by providing coordinated service delivery in the most appropriate, least restrictive environment available.**

Target: To maintain admissions to psychiatric acute care facilities at a maximum of 15%.

Population: Adults assessed as SMI receiving a TennCare Partners service during FY05.

Brief Name: **I/P Admissions**

Indicator: Percentage of adults with SMI receiving TennCare services who are admitted to acute inpatient care.

Measure: % Numerator: Unduplicated # of adults with SMI admitted to inpatient psychiatric acute care

Denominator: Unduplicated # of adults with SMI receiving a TennCare Partners service

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: An acute care admission is defined as one that results in a hospital stay of less than thirty (30) days.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the reduction of the need for inpatient hospitalization.

Name: **I/P Admissions**
Population: **SMI Adult**
Criterion: **1 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	13.8%	15%	15%		
Numerator	13,274				
Denominator	96,284				

Overall inpatient utilization has generally increased since the implementation of managed care. Some of this increase is due to a large increase in population. It is noted that RMHIs are reporting that as high as 50% of admissions are individuals previously unknown to the public mental health system.

Inpatient utilization is monitored by the BHOs and quarterly reports are prepared for review by stakeholder groups. Reports are used by the Department, inpatient facilities, and regional stakeholders to monitor the effectiveness of inpatient care, the continuity of service planning, and the adequacy of community services.

The behavioral health system has increased the number of crisis service contacts, use of respite beds, and availability of 24/7 outpatient triage centers and stabilization services in an effort to decrease the utilization of inpatient beds.

Tennessee mandates a pre-screening evaluation for eligibility for emergency involuntary admission to state mental health institutes. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis.

Criterion 2: Mental Health System Data Epidemiology

Goal 2.1 **To increase access to services for adults receiving behavioral health services through the public managed care system.**

Target: To serve and additional 3,000 adults during FY05.
Population: Adults enrolled in the TennCare Partners Program
Brief Name: **Access**
Indicator: Unduplicated number of adults served by age, gender and race/ethnicity.
Source: DMHDD, Office of Managed Care, Research and Analysis Group
Issues: Decreasing services may reflect the downsizing of the managed care program.
Significance: The impact of impending TennCare reform changes will not be known immediately. Therefore, a modest increase will be targeted.

Name: **Access**
Population: **Adults**
Criterion: **2 (Core – Basic Table 2A)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	126,251 ①	126,250 ②	129,250		
Numerator					
Denominator					

① FY03 URS Table 2a
② Projected from Q1 and Q2 FY04 Progress Reports of the TennCare Partners Program

During FY02 and FY03, some 1.6 million individuals were eligible for some period of time to receive a behavioral health service under TennCare Partners. According to URS Table 2a, some 6,600 more adults received services in FY03 than in FY02. Due to a major redetermination effort for TennCare eligibility during 2003, an estimated 385,000 persons were declared ineligible. No additional open enrollment period has been announced. Enrollment must be by Medicaid eligibility or by meeting financial and medical requirements. By the beginning of FY04, nearly 1.4 individuals were eligible.

Community education about TennCare eligibility and access to services is provided regularly through Bureau of TennCare, BHO and DMHDD efforts.

Goal 2.2 **To ensure access to services for adults with SMI enrolled in the public managed care system.**
Target: To serve an additional 1,000 adults with SMI during FY05.
Population: Adults enrolled in the TennCare Partners Program and assessed as SMI.
Brief Name: **SMI Access**
Indicator: Number of adults with SMI served by age, gender and race/ethnicity.
Source: DMHDD, Office of Managed Care, Research and Analysis Group
Issues: None
Significance: The impact of impending TennCare reform changes will not be known immediately. Therefore, a modest increase is targeted.

Name: **SMI Access**
Population: **SMI Adult**
Criterion: **2 (Developmental – Table 14A)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	88,354	83,000	84,000		
Numerator					
Denominator					

TennCare enrollment for non-Medicaid eligible adults with SMI in need of treatment is expedited. Adults with SMI needing inpatient or outpatient services may be served under a "state-only" category until entitlement eligibility is ascertained.

Preliminary data for FY04 reported in August 2004, when compared with preliminary data reported at the same time in August 2003 for FY03, indicates a 7% decrease in the number of adults with a current assessment of SMI (within the past twelve month period) and a 5% decrease in the number of adults with SMI receiving services. However, due to the time lag in processing encounter data, total fiscal year service counts may differ from this projection.

In FY03, approximately 91% of the eligible adults with a current assessment of SMI received a behavioral managed care service. This number accounted for 70% of the total number of adults receiving a service. Preliminary FY04 data indicates that 93% of adults with a current assessment of SMI received a behavioral managed care service.

Criterion 3: Not Applicable to Adult Plan

Criterion 4: Targeted Services to Rural and Homeless Populations

Goal 4.1 **To assure access to behavioral health services through the public managed care system for adults residing in a rural area.**

Target: To serve 29,000 adults with SMI in rural counties during FY05.

Population: Adults with SMI enrolled in the TennCare Partners Program and residing in a county designated as rural.

Brief Name: **Rural Access**

Indicator: Number of adults served who live in designated rural counties.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: The definition of rural has been adjusted to conform to 2000 Census Definitions, resulting in a drop from 77 of 95 counties designated as rural to 59 of 95 counties designated as rural. The target has been adjusted accordingly.

Significance: Assuring access to mental health services for adults with SMI living in rural areas, especially to encourage use of local resources.

Name: **Rural Access**
Population: **SMI Adults**
Criterion: **4 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	37,204	37,154	29,000 ①		
Numerator					
Denominator					

① The 2000 census description of urban/rural and metropolitan areas decreases Tennessee's rural population demographic to 39% and results in the loss of a rural county designation for eighteen counties. Therefore, projections have been adjusted down to reflect the loss of these counties.

Historically, approximately 42% of TennCare Partners enrollees are from designated rural counties with a similar percentage of rural persons served.

Those individuals living in rural counties, depending on the location of where they spend time for other routine activities; e.g. shopping, leisure, etc. may receive services from a rural county provider or within nearby cities.

Further, some rural residents may prefer to seek behavioral health services outside of their home communities due to perceived stigma or fear of social and/or employment discrimination.

Goal 4.2: **To provide outreach, assistance and referral to homeless adults with SMI.**
Target: To increase by 75 individuals the number of homeless adults who receive case management services through PATH projects.
Population: Adults who are homeless and have a serious mental illness.
Brief Name: **Homeless CM**
Indicator: Number of individuals enrolled in PATH case management.
Source: Annual Report by PATH Agencies to DMHDD
Issues: Homeless populations require trust-building over time with staff having a good knowledge of available resources to promote a "one stop shopping" approach to access a variety of needed services.
Significance: Outreach and case management services are available to homeless adults with mental illness to ensure that persons eligible for services are aware of and have access to needed services.

Name: **Homeless CM**
Population: **Homeless Adults with SMI**
Criterion: **4 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	1,097	1,100	1,175		
Numerator					
Denominator					

During FY05, two additional PATH projects were begun. Each program location has a projected number of outreach contacts and case management enrollment targets. The expansion of federal PATH dollars allows for increased services for this population.

Criterion 5: Management Systems

Goal 5.1: **To provide support and recovery-oriented services for adults with SMI.**

Target: To expend a minimum of 50% of Block Grant funding for recovery-oriented services for adults with SMI.

Population: Priority population Adults

Brief Name: **Recovery**

Indicator: Percent of block grant funds allocated for recovery-oriented services.

Measure: % Numerator: amount of Block Grant dollars spent on recovery-oriented services

Denominator: total amount of Block Grant funding minus administrative costs

Source: DMHDD Budget

Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.

Significance: Non-clinical services, especially recovery and support services are considered important for maintaining wellness, promoting empowerment, improving community reintegration and contributing to improvement in an individual's quality of life.

Name: **Recovery**
Population: **Adults with SMI**
Criterion: **5 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	55%	57%	50%		
Numerator	4,298,600	4,532,880			
Denominator	7,806,700	7,900,900	7,730,700		

Proposed allocations include projects in assisted living, consumer support and educational activities, including BRIDGES, and consumer run Drop-in Centers. Each of these service projects feature mentoring, education, and peer support activities to aid each consumer to recover to the best of his or her ability.

Goal 5.2: **To conduct a statewide multi-media campaign to educate the public about mental illness and effective treatments that promote remission and recovery.**

Target: To promote knowledge of and decrease stigma around mental health services.

Population: General Public

Brief Name: **Stigma**

Indicator: Number of calls received on DMHDD ombudsman telephone line requesting information and referral for mental health services.

Source: Ombudsman Telephone Log

Issues: Unawareness of service availability and how to access impact utilization.

Significance: Stigma continues to surround the subject of mental illness and can lead to discrimination in life and community activities.

Name: **Stigma**
Population: **General Public**
Criterion: **5 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	N/A	104	146		
Numerator					
Denominator					

As stated in the President's New Freedom Commission on Mental Health report, stigma deters individuals from seeking care. Responding to stigma, people with mental health problems internalize public attitudes and become embarrassed or ashamed and fail to seek treatment.

A multi-media campaign not only allows for education of the public regarding the availability and accessibility of services, but reduces stigma by openly discussing treatment availability and effectiveness.

b) CHILDREN'S PLAN

1) Current Activities

i. Criterion 1 A Comprehensive Community-Based System of Care

Mental Health Services: As of April 1, 2003, access to any TennCare Partners service is accomplished by meeting the medically necessary criteria for that service or being referred through EPSDT screening services. Benefits include:

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient/Residential and Outpatient Substance Abuse Treatment Services
- (10 days detox and $30,000 lifetime limit for non-priority population enrollees)
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Specialized Outpatient and Symptom management
- Specialized Crisis Services and Respite

In addition to the TennCare medical and behavioral health benefit package, the following services are available within the comprehensive array of community services:

Rehabilitation Services
There are no targeted rehabilitation services for children and youth. However, rehabilitative activities occur within a number of day treatment, respite, educational, residential, and transitional program activities.

Employment Services: The Department of Education (DOE) requires transition plans to be included in the Individual Education Plans of all children in special education who are fourteen years or older, some of whom are assessed as SED. This includes the assessment of vocational alternatives. The Division of Rehabilitation Services provides transition-from-school-to-work case managers within the schools and designates Rehabilitation Counselors to work with a school.

Housing Services: The DCS provides highly structured, staff secure, community-based, twenty-four hour residential treatment for a specialized sub-population of children and youth with SED. DCS also supports a foster care program.

Educational Services: Day treatment services are funded for children and youth with SED through the TCPP. DMHDD has recommended school-based day treatment to be the preferred model for delivering this service. Non-school-based day treatment programs, which provide education as a component of the program, must qualify as approved schools per DOE policies and procedures.

Medical and Dental Services: Primary Care Physician and Specialist Medical Services are available under TennCare. EPSDT assessments are expected for all Medicaid enrolled children under twenty-one. Medical and dental services are provided as medically necessary for children and youth who are eligible for TennCare. A move to a single dental benefit manager has markedly improved access to dental care and increased participation of dentists in the program.

Substance Abuse Services: Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of both the BHOs and the DOH, Bureau of Alcohol and Drug Abuse Services.

Case Management Services: Mental health case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. Mental Health Case Management Services are an available benefit of the TennCare Partners Program. As of July 2004, members will be assessed for level one and level two case management services regardless of priority population status. The assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. The BHOs have documented policies regarding all level one and level two case management caseload capacities and expected consumer outcomes.

Case management services for children and youth include the more intense Continuous Treatment Teams and Comprehensive Child and Family Treatment Teams.

Services for Co-occurring Disorders (COD): Children with co-occurring disorders have access to the range of services offered by TennCare and the BADAS. The TCPP has pursued the development of intensive outpatient services for adolescents with co-occurring disorders in targeted deficit areas. Funding allocations in FY04 include four specialized programs to serve youth with Substance Abuse and COD in thirty-one counties across Tennessee.

Services for Special Populations: DMHDD supports the following service initiatives for children and youth with special needs:

- Services for Children and Youth with Dual Diagnosis of SED and Mental Retardation or Developmental Disability: Funding allocations in FY04 include three projects to provide therapeutic foster care, case management, and intensive in-home treatment and support services for dually diagnosed children and youth.

- Services for Children and Youth in the Juvenile Justice System: Forensic evaluation and treatment services are provided for youth under Juvenile Court Order. Funding allocations in FY04 include juvenile sex offender assessment and treatment programs in six locations across Tennessee.

- Services for Children of Parents with SMI: This is a program to provide education and support for children and youth who have a parent diagnosed with a mental illness with a school-based outreach curriculum, Mental Health 101.

- Erase the Stigma Project: Contracted through the Mental Health Association, these funds support a statewide anti-stigma program for children and youth through mental health presentations both in schools and in the community. Events, project goals, and presentations are developed in collaboration with major children's advocacy groups.
- Statewide suicide prevention hotline, support groups, and staff training in suicide prevention.

Activities to Reduce Hospitalization

- A pre-screening evaluation for eligibility for emergency involuntary admission to state mental health institutes. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis. Pre-screeners assessing children must meet additional experience criteria working with children.
- Specialized crisis services targeted to intervention with children and youth and their families.

Support Services: DMHDD supports the following support services:

- Tennessee Voices for Children (TVC), the Tennessee affiliate of the Federation of Families for Children's Mental Health, manages a family support group network across the state for families of children with SED, with family groups in each of the three grand regions of the state. TVC provides technical assistance and consultation for the development of these groups, distributes printed materials, refers families to services, and performs parent advocacy and training activities through family outreach specialists.
- Planned Respite Services: A model program that provides respite services to families of children identified with SED or dually diagnosed with SED and mental retardation ages two to fifteen.
- Parent/Professional Support Groups: These support groups are co-lead by both a parent of a child with SED and a professional. The member families determine the agenda and hire their own professional co-facilitator. Respite consultants provide short-term respite and work with the family to identify long-range respite resources.

All services under Criterion 1 have been implemented. The focus on building systems of care statewide is expected to increased provider collaboration and consumer and family outcomes.

ii. Criterion 2 Mental Health System Data Epidemiology

DMHDD provides an annual table of prevalence and penetration. Based on prior year numbers much above the highest estimates provided in the Federal Register, Tennessee will utilize the lower 7% of the under eighteen population to more closely

approximate the federal estimate of prevalence of SED. The number of these youth that could be expected to access the public mental health system is unknown.

Table 2.01 below shows estimates based on the above criteria as well as the TennCare enrollment of that population during FY04.

TABLE 2.01 ESTIMATED # OF PRIORITY POPULATION AND TENNCARE ENROLLMENT

2000 Census TN population (Under 18)	Estimated % SED	Total SED	SED TennCare Enrolled FY04 ①	Penetration Rate
1,399,564	7%	97,969	67,614	69%

① Individuals with a TPG assessment code 2 (SED) enrolled in TennCare for any period of time during July 2003 through June 2004. Source: Research and Analysis, Office of Managed Care, DMHDD, August 2004.

Tennessee utilizes the federal definition of SED: "Children and adolescents from birth up to age eighteen years who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities." Children and youth are classified with a Targeted Population Group (TPG) form. The degree of functional impairment is assessed with the Global Assessment of Functioning (GAF). Those meeting the federal definition with a GAF of 50 or below are considered SED and classified as TPG 2.

During FY05, DMHDD Block Grant and state funded services are estimated to provide services to 137,000 children and their families.

Further quantitative goals for FY05 are included in the Goals, Targets, and Action Plan section beginning on page 75.

iii. Criterion 3 Children's Services

The system of mental health care for children and youth, including children and youth with SED, consists of four service delivery entities: TennCare/TennCare Partners; DCS for children in or at risk of state custody; DMHDD-contracted services and state hospitals; and the DOH, Bureau of Alcohol and Drug Abuse Services.

- The Bureau of TennCare contracts with MCOs and DMHDD contracts with BHOs to deliver medically necessary physical care, mental health care, and substance abuse services, including EPSDT assessments for TennCare eligible children and youth to age twenty-one. The Memorandum of Understanding (MOU) between the Bureau of TennCare and DMHDD serves to further the integration of policy and program development for children and youth receiving services under the TCPP.

- DCS was created by joint effort of the General Assembly and the Governor's Office in July 1996 to fulfill the state's responsibilities for children committed to, or at risk of commitment to, the state's custody. These custodial duties were previously distributed across the Departments of Mental Health and Mental Retardation, Human

Services, Youth Development, and Education. DCS provides for children who are placed in state custody, or are at risk of placement in state custody.

DCS provides an array of services to children and youth in legal and physical state custody. Many of these children enter custody due to neglect, abuse, abandonment, delinquency, or are awaiting adoption. As of March 31, 2004, 10,523 children were in DCS custody. Of these children, 822 were under two years of age, 1,247 range in age from two to four years, 2,849 range in age from five to twelve years, and 5,604 were ages thirteen to eighteen.

Almost all custodial children and youth are enrolled in TennCare. The TCPP provides for medically necessary services with the exception of residential treatment services, which are the responsibility of DCS. Mental health case management services for children in state custody with SED can be accessed through the TCPP.

- DMHDD, through Block Grant funding and state appropriations, contracts with multiple agencies to deliver education, prevention, early intervention, respite, and outreach mental health services for children and youth with or at risk of SED.

  DMHDD manages children and youth inpatient psychiatric programs that provide acute and extended care in two of the state psychiatric hospitals and contracts for outpatient and inpatient mental health evaluations of children and youth ordered by juvenile courts.

- The Bureau of Alcohol and Drug Abuse Services provides for education, early intervention, and non-TennCare-covered substance abuse treatment services for children and youth through state funding and the Substance Abuse Block Grant.

Tennessee's integrated statewide system of services for children and youth with SED includes social, education, juvenile justice, substance abuse, and mental health.

The service integration is accomplished via multiple linkages and interactions between the four primary departments of state government that serve youth and their respective networks of provider agencies. The Departments of Health, Education, Children's Services and Mental Health and Developmental Disabilities each have complementary responsibilities for meeting the needs of children and youth.

- Social Services: DMHDD provides consultation to DHS staff on mental health treatment issues, community resources, and referral procedures to utilize in the training of case managers who will work with special needs families participating in Tennessee's welfare to work program, Families First.

- Educational Services: The DOE approves the special education annual plans of all schools operated by DMHDD and DCS. Staff from each department participates in common projects (e.g. Dropout prevention, Family Resource Centers). In addition, DMHDD has an extensive presence in school systems with the Jason Foundation curriculum and, particularly, in rural areas with Project BASIC. (See service descriptions in C&Y Criterion 5 on page 72 and 73.)

- Juvenile Services: DMHDD contracts for court-ordered evaluations and mental health services for children and youth committed by the juvenile court. Both inpatient and outpatient evaluation services are provided. DMHDD Forensic Services staff monitor all evaluations and assist in accessing recommended treatment services as necessary.

- Substance Abuse Services: The Bureau of Alcohol and Substance Abuse Services provides a number of prevention programs for children, including intensive focus groups, the Tennessee Teen Institute, and The Faith Initiative targeting pre-adolescent children living in single parent households in inner-city housing developments.

  Bureau-funded treatment services are primarily targeted to persons with no other means of paying for treatment. Funding also targets special needs populations such as pregnant women, women with dependent children, adolescents, and persons of any age at risk for or infected with HIV.

- IDEA Services: PL 105-17, the Individuals with Disability Education Act is administered by the DOE. Services and activities developed under Tennessee's Part C process include: an 800 telephone number information and referral line, a directory of services available in each area of the state, child-find activities, community awareness activities, and contracted mental health case management services. All children included in Part C have an Individualized Family Service Plan and appropriate services provided. An Interagency Coordinating Council meets regularly to guide these activities and to develop and monitor the State's Plan for Part C. Disabilities that can be served under Part C include social and emotional delay.

  Special education and related services for children and youth with SED are specified in an Individualized Education Plan and provided by the local education agencies, the DCS contract provider or facility school for children in state custody, or schools operated by DMHDD for children and youth in RMHIs. An interagency agreement defines the fiscal responsibilities for special education related services between DOE and the Bureau of TennCare.

iv. Criterion 4 Targeted Services to Rural and Homeless Populations

Rural

The U.S. Census Bureau's definition language for rural is "all territory, population, and housing units located outside of urbanized areas and urban clusters". For purposes of defining rural counties, we will define a "rural county" as one that has 50% or more of its population in a rural area and is not included in the Metropolitan Statistical Areas county list. This information is obtained from the 2003 Tennessee Statistical Abstract.

Using the above definition, the number of defined "rural" counties in Tennessee would drop from seventy-seven to fifty-nine.

The TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations.

Tennessee augments traditional clinical services with alternative services designed to decrease discrimination, engage rural families, and provide opportunities for education and support in areas where there are few community resources.

- The great majority of C&Y Project BASIC sites are in poor, rural areas of the state and are a partnership between a local school and the local CMHC.
- DMHDD involves individuals from rural Tennessee in the planning process and has ensured that there is representation from families, consumers, providers and other advocates from rural areas on all state and regional councils. The Department provides travel reimbursement to consumers and family members in an effort to encourage participation.
- The Department's Family Support and Advocacy Program, implemented by the Tennessee Voices for Children (TVC), operates statewide and has successfully provided community education in rural areas of the state, based on needs assessment surveys of the community.
- The Mental Health Association of Middle Tennessee, in conjunction with Tennessee Rotary Clubs, sponsors "Erase the Stigma" presentations statewide to school, civic, and community groups. Fifty percent (50%) of presentations are required to be in rural counties.

Homeless

The TCPP provides a continuum of services for all eligible children with SED. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes. Homeless children and youth who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost family support groups.

DMHDD funds outreach case management services for homeless children and youth with SED, or at risk of SED, in the Nashville/Davidson County area, the Johnson City area, and in the cities of Chattanooga, Knoxville, Jackson, and Memphis.

Homeless Outreach staff assist homeless families in identifying children and youth with SED or who may be at risk of SED. Staff assist the parent(s) in securing needed mental health services for their children and link them with other services needed to keep the family intact and healthy. Outreach staff also refer children for EPSDT screening, which often is the first contact with medical services since birth.

The homeless outreach worker functions as a liaison between the school and the family when special education services are needed, facilitates mental health evaluation and

treatment, and assists the family in securing more permanent housing. Staff provide assistance until the family becomes linked with more durable, on-going case management, treatment, and social service agencies, is no longer homeless, or no longer accepts services.

DMHDD funds each of the programs with flexible funding to purchase a variety of goods and services that are not otherwise funded such as emergency housing, respite, therapeutic summer camp, clothes, school supplies, transportation, and emergency child care.

There are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. One site has sixteen apartments dedicated for women with SMI and their children.

v. Criterion 5 Management Systems

Financial Resources

Tennessee made available $412,369,500 in capitation payments made monthly to the BHOs for services provided to TennCare Partners Program enrollees through June 30, 2004. The State continues financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees that it assumed as of July 1, 1999. The pharmacy cost for individuals for FY04 in the community amounted to $616,514,200 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities. This reflects a nearly 58% increase in pharmacy costs over FY03.

The cost of providing forensic and court-ordered evaluations performed at the five RMHIs and in the community is estimated at $24,788,700 dollars.

DMHDD funded community mental health services, excluding forensic and court ordered evaluations, at $23,383,500. This funding includes the CMHS Block Grant award and other federal grants received by the DMHDD. Further, the five RMHIs expended $60,107,300 above revenue received from the two BHOs to provide inpatient mental health services.

In total, roughly $1,137,163,200 was directed for the provision of mental health services to individuals within Tennessee for FY 04 with the goal for this level of funding to be maintained or increased in FY 05.

DMHDD continues to enter into grant agreements to provide mental health service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHAs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

State expenditures for services to children and youth in FY04 totaled $18,531,897. The 2004 CMHS Block Grant award is $8,137,479. Funding in the amount of $7,730,700, 95% of the total award, has been granted to community based programs in accordance with the expectations of the grant. Nearly 33% of the Block Grant award is contracted for services to children and youth. Approximately 5% of the award, or $406,779,

supports administrative functions relative to the community mental health system and State Mental Health Planning and Policy Council activities.

Staffing
DMHDD employs approximately 2,900 staff, 178 in Central Office and the remainder in the five state psychiatric hospitals for approximately 950 service recipients.

The state contract with the medical and behavioral health organizations requires those entities to maintain an adequate provider base to provide services to individuals covered under the benefit plan.

The BHO's outpatient network consists of around 1,200 credentialed and contracted individual and group providers, exclusive of individual Community Mental Health Center staff. Additional resources for children and youth include:

- 13 providers of 24-hour residential treatment at 14 locations
- 16 providers of inpatient psychiatric services at 16 locations
- 14 providers of inpatient substance abuse services at 15 locations
- 1 provider of crisis response services for 95 counties

Training
BHO consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires BHOs to offer the following:

1. an educational plan for providers formulated with input from the BHO Advisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2. cross-training of mental health and substance abuse providers;
3. mental health training for primary care providers; and
4. assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

In addition to routine networking opportunities, monitoring and technical assistance, DMHDD provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups and special grant recipients.

- The Regional Intervention Programs (RIP) provide training as an essential element of the model - parent training of behavior management. Statewide training is provided to new resource coordinators at the Nashville location. RIP staff and statewide RIP technical assistance staff conduct training.

- BASIC project staff receive intensive training at initial implementation and as staff turnover occurs. Technical assistance is available on request and is provided during site visits.

- The Tennessee Respite Network training curriculum for respite providers is offered several times per year or as requested. The network maintains specialized training

curricula for problem issues. DMHDD participates in sponsoring an annual Tennessee Respite Conference.

- Nashville Connection staff sponsor and assist in conducting training workshops on wraparound services and system of care planning, including the development of marketing tools. Staff also make presentations at conferences and meetings on the integrated services model.

DMHDD staff overseeing service contracts for children and youth provide regularly scheduled training for Homeless Outreach staff and suicide prevention action groups.

Training Providers of Emergency Health Services
(See Adult Criterion 5 on page 48.) BHO provider training and all-hazards response training includes education about specific responses and interventions for children and adolescents.

Expenditure of 2005 Block Grant Allocation
DMHDD utilizes its Block Grant funding for the provision of non-clinically related community mental health services for adults with SMI and children and youth with, or at risk of, SED. Services are designed to reduce the use of hospitalization; promote education, prevention, and early intervention; integrate services; and build a reliable community support service system that emphasizes empowerment, recovery, and normalization for individuals and families.

Currently, eleven private, not-for-profit CMHCs and five other community agencies receive federal mental health block grant funds to provide services to children and youth. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.) Agencies provide services within their service areas.

Some $2,513,200 in CMHS Block Grant funding will be allocated for children and youth services in accordance with Criterion 1, 2, 3, 4, and 5 in the following manner:

BASIC $ 1,596,500
Project BASIC (Better Attitudes and Skills in Children) is an elementary school-based mental health early intervention and prevention service that works with children from kindergarten through third grade. Goals are to enhance awareness and capacity for response of school personnel to the mental health needs of children and to reduce the incidence of adolescent and adult mental health problems. Children with SED are identified and referred for mental health services. Funds support BASIC programs at forty-seven elementary school locations.

Planned Respite Services $ 619,700
This is a program that provides respite services to families of children identified with serious emotional disturbance, or dually diagnosed with SED and mental retardation, who are ages two to fifteen. Respite consultants provide short-term respite and work with the family to identify long-range respite resources. Individualized family respite plans are developed with the family. The consultant enables families to develop community-based respite resources and utilize them effectively.

Funding supports respite services in each of the seven mental health planning regions across the state. Included in the total is $30,000 that supplements state dollars to fund a voucher program to pay for respite services for children ages birth to eighteen of families who reside in Memphis/Shelby County.

Early Childhood Network $ 145,000
This is a collaborative effort on the local level to identify and address the mental health needs of preschool through third grade children through prevention and early intervention strategies. The effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with this age group. Funding supports projects in two counties that currently have RIP, BASIC, and Day Care Consultation and have identified gaps in services.

Jason Foundation School Curriculum $ 77,500
In response to the Surgeon General's Call to Action to Prevent Suicide Plan, one of Tennessee's strategies targets providing educational programs for youth that address suicide. The Jason Foundation offers a Triangle of Prevention approach for awareness and prevention of youth suicide. The project addresses youth, parents, teachers, and educators from middle school to college in suicide awareness and prevention through educational programs and seminars.

NAMI-TN Parent Education $ 47,500
"Visions for Tomorrow" is a program that provides education for families of children with SED, utilizing a train-the-trainer model. The goal of the program is to empower parents and guardians to become advocates for their children and to develop tools to help other families in a supportive, educational manner.

Suicide Prevention $ 18,000
Funds supplement state dollars to support the Tennessee Suicide Prevention Network, a statewide coalition that developed and now oversees the implementation of strategies to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma associated with suicide, and educate communities throughout the state about suicide prevention and intervention.

Strengthening Families-Renewal House $ 4,000
Funding supplements other state dollars to support early intervention and prevention services to children at risk of SED or substance abuse who reside at Renewal House, a residential program for addicted mothers in recovery and their children. Services provide on-site child, family and group counseling for which there is no third-party payer source. Parenting classes, support groups and family enrichment are provided for family preservation. Therapeutic services are also provided for children when evaluations deem such services appropriate.

Cultural Competency $ 5,000
Cultural and Linguistic competency promotion is targeted for mental health agencies, mental health providers and mental health interpreters.

Table 5.02 on page 74 details the proposed 2005 Block Grant contract amounts for C&Y services by agency and program.

TABLE 5.02 PROPOSED 2005 BLOCK GRANT CONTRACT AMOUNTS FOR C&Y SERVICES

CMHC	BASIC	Strength. Families/ CC	Early Child Network	Jason/ NAMI/ TSPN	Planned Respite	Total
Frontier	279,557	0	0	0	81,112	$360,669
Cherokee	70,028	0	0	0	0	$70,028
Ridgeview	40,016	0	0	0	81,112	$121,128
Volunteer	280,110	0		0	184,040	$536,650
Fortwood	40,016	0	0	0	0	$40,016
Centerstone	263,887	0		0	81,112	$447,499
Carey	120,048	0	0	0	0	$120,048
Pathways	120,047	0	0	0	0	$120,047
Quinco	222,727	0	0	0	81,112	$303,839
Professional Counseling	160,064	0	0	0	0	$160,064
Frayser	0	0	0	0	81,112	$81,112
OTHER AGENCY						
TN Respite Coalition	0	0	0	0	30,100	$30,100
Renewal House	0	4,000	0	0	0	$4,000
Jason Foundation	0	0	0	77,500	0	$77,500
Crisis Intervention Center	0	0	0	18,000	0	$18,000
MHA of Mid TN	0	5,000	0	5,000	0	10,000
NAMI TN	0	0	0	47,500	0	$47,500
TOTAL C&Y	**$1,596,500**	**$9,000**	**$ 145,000**	**$**	**$619,700**	**$ 2,513,200**
					Total Adult	$ 5,217,500

					Total Both	**$ 7,730,700**
					Admin. 5%	**$ 406,779**
					TOTAL BG	**$ 8,137,479**

2) Goals, Targets and Action Plans

Criterion 1: Comprehensive, Community-Based System of Care

Goal 1.1: **To maximize the ability to remain in a community setting by providing coordinated service delivery in the most appropriate, least restrictive environment available.**

Target: To maintain the number of admissions to psychiatric acute care facilities at a maximum of 10%.

Population: TennCare enrolled children and youth assessed as SED and receiving TennCare Partners services during FY05.

Brief Name: **C&Y Admissions**

Indicator: Number of admissions to acute inpatient care by children and youth in the priority population who are receiving services.

Measure: % Numerator: Unduplicated # of children and youth with SED admitted to inpatient psychiatric acute care

Denominator: Unduplicated # of children and youth with SED receiving a TennCare Partners service

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: An acute care admission is defined as one that results in a hospital stay of less than thirty (30) days.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the reduction of the need for inpatient hospitalization.

Name: **C&Y Admissions**
Population: **TennCare Enrolled SED**
Criterion: **1 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	8.6%	5.5%	10%		
Numerator	2,295	1,442			
Denominator	26,552	26,013			

Community treatment options for children with SED have been increased and a dedicated children and youth crisis service initiated. System of Care initiatives have shown positive impact in hospitalization rates of children receiving care.

Goal 1.2: **To provide case management services to children and youth with SED receiving benefits under TennCare. .**

Target: To provide mental health case management services to a minimum of 50% of children and youth with SED.

Population: TennCare enrolled children and youth with TPG assessment of 2 receiving a TennCare Partners service during FY05.

Brief Name: **C&Y CM**

Indicator: Percentage of children and youth in the priority population who receive a mental health case management service

Measure: % Numerator: Unduplicated # of children with SED receiving a mental health case management service
Denominator: Unduplicated # of children with SED receiving any TennCare Partners service

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: Enrollment of children and youth under the age of eighteen is dependent upon parental or guardian acceptance of the service on behalf of the child.

Significance: Assuring access to case management services for children and youth with SED is a primary goal of community-based services and a commitment of DMHDD and TennCare.

Name: **C&Y CM**
Population: **TennCare Enrolled SED**
Criterion: **1 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	56%	55%	50%		
Numerator	14,861	14,295			
Denominator	26,552	26,013			

Children and youth with SED are assessed for case management according to level of need. Intensity levels range from assertive community treatment teams to case coordination.

Criterion 2: Mental Health System Data Epidemiology

Goal 2.1 **To increase access to services for C&Y with SED receiving behavioral health services through the public managed care system.**

Target: To serve an additional 1,000 C&Y with SED during FY05.
Population: C&Y enrolled in the TennCare Partners Program and assessed as SED.
Brief Name: **SED Access**
Indicator: Number of C&Y with SED served by age, gender and race/ethnicity.
Source: DMHDD, Office of Managed Care, Research and Analysis Group
Issues: None
Significance: The impact of impending TennCare reform changes will not be known immediately. Therefore, a modest increase is targeted.

Name: **SED Access**
Population: **C&Y Enrolled in TennCare Partners**
Criterion: **2 (Developmental Table 14A)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	26,552	26,500	27,500		
Numerator					
Denominator					

Within the past two years, numerous new service initiatives for children have been developed. These include expansion of CTTs for children and youth, Comprehensive Child and Family Treatment Teams for high intensity, time limited services to deter out of home placement or incarceration, and services for special populations of children and adolescents.

There was a 6.8% increase in the number of children and youth with SED served between FY02 and FY03. However, preliminary data for FY04 project a slight decrease in services to this population.

Criterion 3: Children's Services

Goal 3.1. **To offer effective inpatient treatment and continuity of care to maximize community tenure.**

Target: To decrease the rate of readmission to any psychiatric inpatient hospital within 30 days and within 180 days of discharge.

Population: Children and youth under age 18 receiving a TennCare Partners psychiatric inpatient service during FY04.

Brief Name: **I/P Readmission**

Indicator: Percentage of C&Y discharged from inpatient services who are readmitted to inpatient care within 30 days and within 180 days.

Measure: % Numerator: Unduplicated # of C&Y readmitted within 30 and 180 days of discharge.
Denominator: Unduplicated # of C&Y discharged from psychiatric inpatient care during FY04.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: Readmission is defined as admission to any inpatient psychiatric hospital within 30 or 180 days of a discharge from inpatient stay.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment and the continuity of community care.

Name: **I/P Readmission – (30 days) ①**
Population: **C&Y enrolled in the TennCare Partners Program**
Criterion: **3 (State/Core – Developmental Table 21)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	13.4%	13%	13%		
Numerator	432				
Denominator	3,230				

Name: **I/P Readmission – (180 days) ①**
Population: **C&Y enrolled in the TennCare Partners Program**
Criterion: **3 (State/Core – Developmental Table 21)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	25%	24%	24%		
Numerator	808				
Denominator	3,230				

① Due to the post fiscal year timeframe for readmission, data reported in FY05 will be for the previous fiscal year.

Readmission rates, at least within 30 days, are often dependent upon continuity of care and connection with community treatment and support services.

Data Infrastructure Grant "issues" notes regarding the Uniform Reporting System (URS) tables indicate that the ideal is to expand reporting to include all readmissions to any hospital, not just state hospitals. Since Tennessee has this capacity within its managed care program, Table 21 has been reported rather than Table 20B, readmissions to state hospitals only. Both tables will be reported with the December 1, 2004 submission of the URS data.

BHO standards of care require case management assessment for individuals being discharged from inpatient care with a case manager face-to-face encounter within seven days and routine outpatient services available within fourteen days. Outpatient providers are required to maintain access logs of initial appointments and performance is monitored by both the BHO and DMHDD.

The BHOs contract with sixteen psychiatric facilities to provide inpatient care to children and youth. Two of these contracted facilities are state psychiatric hospitals.

Goal 3.2: **To provide behavioral health services to children and youth that are rated positively by families/caregivers.**

Target: To increase to 70% the consumers/families who report positively about service outcomes for their children.

Population: C&Y receiving services through the TennCare Partners Program during FY05.

Brief Name: **Outcomes**

Indicator: Percentage of persons submitting a positive survey response on outcomes.

Measure: % Numerator: Unduplicated # of individuals reporting positive response to survey question on outcomes.
Denominator: Unduplicated # of individuals responding to child/adolescent survey.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: None

Significance: A positive perception of care increases the likelihood of continued service acceptance and positive movement toward recovery.

Name: **Outcomes**
Population: **C&Y Receiving TennCare Partners Services**
Criterion: **3 (Core – Basic Table 11a)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	69%	69%	70%		
Numerator	303				
Denominator	436				

The annual survey questions perceived outcomes. Other DMHDD contract programs also include annual surveys and event questionnaires requesting feedback on the effectiveness of services or information.

Goal 3.3: **To provide behavioral health interventions for which there are consistent, scientific evidence showing that they improve consumer outcomes.**

Target: To increase by 50 the number of consumers receiving an Evidenced Based Practice (EBP).

Population: C&Y assessed as SED receiving a TennCare Partners service during FY05.

Brief Name: **EBP**

Indicator: Number of children and youth receiving an evidenced based practice as defined by CMHS.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: State's may be providing other services qualified to be evidenced based practices that are not included in the CMHS table listing.

Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Name: **EBP**
Population: **C&Y with SED**
Criterion: **3 (Core – Developmental Tables 16 and 17))**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	1,339	1,360	1,400		
Numerator					
Denominator					

URS Tables 16-17 List of Evidenced Based Practices for children include:

1. Assertive Community Treatment — Yes
2. Therapeutic Foster Care — Yes (limited)

There are approximately twenty-five CTTs for children and youth under the behavioral managed care umbrella. The teams prioritize children and youth with SED who are at risk for out-of-home placement or those with multiple needs from multiple agencies.

In addition to the services listed above, DMHDD also provides BASIC and RIP programs across the state, both nationally recognized and researched programs for the early identification and treatment of young children.

Goal 3.4 **To increase access to services for C&Y receiving behavioral health services through the public managed care system.**
Target: To serve and additional 1,000 children and youth during FY05.
Population: Children and youth under 18 enrolled in the TennCare Partners Program
Brief Name: **Access**
Indicator: Unduplicated number of C&Y served by age, gender and race/ethnicity.
Source: DMHDD, Office of Managed Care, Research and Analysis Group
Issues: Decreasing services may reflect the downsizing of the managed care program.
Significance: The impact of impending TennCare reform changes will not be known immediately. Therefore, a modest increase will be targeted.

Name: **Access**
Population: **Children and Youth**
Criterion: **3 (Core – Basic Table 2A)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	45,541 ①	45,550 ②	46,550		
Numerator					
Denominator					

① FY03 URS Table 2A
② Projected from Q1 and Q2 FY04 Progress Reports of the TennCare Partners Program

The number of children and youth receiving behavioral health care services rose by approximately 7.5% between FY02 and FY03. However, preliminary projections indicate a slowing of service encounters in general.

First quarter data for FY04 indicates that there are 586,539 children and youth under the age of eighteen eligible for TennCare services. Approximately 8% of them accessed behavioral health care services during FY03. Only 4% of the total number are assessed as SED; however, children and youth with SED do show higher rates of service encounters.

Goal 3.5: **To ensure substance abuse service access for children and youth with co-occurring disorders (COD) of SED and substance abuse.**

Target: To increase the number of children and youth with COD who are accessing substance abuse services.

Population: Children and youth enrolled in TennCare dually diagnosed with SED and a substance abuse disorder.

Brief Name: **C&Y SA**

Indicator: Percent of children with COD who receive a substance abuse service through the behavioral managed care system.

Measure: % Numerator: Unduplicated # of children and youth under 18 receiving a substance abuse service.
Denominator: Unduplicated # of children and youth with COD.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: For the Bureau of Alcohol and Drug Abuse Services data, the field will be limited to those under eighteen with a mental health diagnosis who receive a service under the Substance Abuse Block Grant.

Significance: While integrated services is the optimal service goal, the ability to access appropriate inpatient and outpatient substance abuse services is critical for those with COD.

Name: **C&Y SA**
Population: **COD**
Criterion: **3 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	85.7%	36%	40%		
Numerator	596	620			
Denominator	① 695	② 1,734			

① FY03 data based on C&Y with SED and primary diagnosis of substance abuse.
② FY04 data based on C&Y with SED and any other diagnosis of substance abuse.

FY03 data indicates a fairly high percentage of children and youth with SED and a primary substance abuse diagnosis are receiving addiction treatment. FY04 data includes all diagnostic fields that include a substance abuse diagnoses.

Children and youth under age eighteen may receive treatment services through the DOH, BADAS. However, in FY03, less than 100 children with a mental health diagnosis received a substance abuse service apart from the managed care system.

Providers are often reluctant to "label" children with a substance abuse diagnosis, but once diagnosed, appropriate treatment should be forthcoming.

Criterion 4: Targeted Services to Rural and Homeless Populations

Goal 4.1 **To assure equitable access to behavioral health services through the public managed care system.**

Target: To serve an additional 300 rural C&Y with SED during FY05.

Population: C&Y with SED residing in a rural county and enrolled in TennCare Partners.

Brief Name: **Rural Access**

Indicator: Number of children and youth who live in designated rural counties and receive a behavioral health service through the managed care program.

Source: DMHDD, Office of Managed Care, Research and Analysis Group

Issues: The definition of rural has been adjusted to conform to 2000 Census definitions, resulting in a drop from 77 of 95 counties designated as rural to 59 of 95 counties designated as rural. The target has been adjusted accordingly.

Significance: Assuring access to mental health services for C&Y with SED living in rural areas, especially to encourage use of local resources.

Name: **Rural Access**
Population: **C&Y with SED**
Criterion: **4 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	① 10,629	10,100	② 8,450		
Numerator					
Denominator					

① FY03 and FY04 data is based on encounter data from individuals residing in seventy-seven counties designated as rural.
② FY05 projections are based on encounter data from individuals residing in fifty-nine counties designated as rural.

The 2000 census description of urban/rural and metropolitan areas decreases Tennessee's rural population demographic to 39% and results in the loss of a rural county designation for eighteen counties.

Approximately 38% of TennCare Partners enrollees assessed as SED and receiving a TCPP service during FY04 were from designated rural counties. Ninety-five percent (95%) of children and youth with a current assessment (within twelve months) of SED and residing in a rural county received a behavioral health service.

Goal 4.2: **To provide outreach to homeless families with children to promote assessment and needed service access.**

Target:: To assure that homeless families and their children receive linkage to appropriate community services and resources.

Population: Homeless parents and children suspected of SED or at risk of SED.

Brief Name: **Referral**

Indicator: Percentage of family members accessing needed services after referral by the C&Y Homeless Outreach Team.

Measure: % Numerator: Number of families accessing resource.
Denominator: Number of referrals by Team.

Source: C&Y Homeless Outreach Project Annual Report

Issues: Indicator includes parent referrals for TennCare enrollment, mental health services, and vocational rehabilitation; child referrals to mental health services and EPSDT screening.

Significance: Children of homeless families are at increased risk of experiencing physical neglect and/or developing behavioral and/or emotional problems or substance abuse.

Name: **Referral**
Population: **Homeless Families with Children**
Criterion: **4 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	60%	60%	62%		
Numerator	927				
Denominator	1,526				

The goals of this program are to provide outreach services for homeless families to identify children and youth who may be SED or who may be at risk of SED, assist the parent in securing needed mental health services for their children (and often themselves), and link the parents with other services needed to keep the family intact and healthy.

While assessment and service access are available for homeless families with children with SED, or at risk of SED, follow-up with a referral is dependent on follow-through by the parent(s) and system capacity. Homeless Outreach staff training includes strategies to maximize the willingness and ability of parents to follow-through on recommended referrals.

Goal 4.3: **To assist homeless families with children to secure permanent housing.**

Target: To increase the number of families who are no longer living in shelters or other non-permanent or sub-standard locations.

Population: Families with children receiving services through the C&Y Homeless Outreach Program.

Brief Name: **C&Y Homeless**

Indicator: Percentage of families with children who secure permanent housing.

Measure: % Numerator: Unduplicated # of families with children securing permanent housing.
Denominator: Unduplicated # of families with children receiving homeless outreach services.

Source: C&Y Homeless Outreach Project Annual Report

Issues: Children's risk of experiencing behavioral, emotional, and/or substance abuse problems may increase with extended periods of homelessness.

Significance: Access to permanent housing options for homeless families with children, especially those with SED or at risk of SED, is more likely to promote child and family stabilization.

Name: **C&Y Homeless**
Population: **Homeless Families with Children**
Criterion: **4 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	33%	20%	30%		
Numerator	161	83			
Denominator	488	410			

While the primary goal of the Homeless Outreach Project is the early identification of at risk children and youth, a secondary goal is keeping the family intact and healthy. Permanent housing can present a family a better environment than separate shelters, a car, or the street in which to develop or regain family stability. Additionally, some families access emergency or transitional housing.

Criterion 5: Management Systems

Goal 5.1: **To ensure a proportion of Block Grant funding for early intervention and prevention services for children and youth.**

Target: To maintain at least 20% of Block Grant funding for early intervention and prevention services.

Population: Children and Youth with SED, or at risk of SED

Brief Name: **C&Y Allocation**

Indicator: Percentage of block grant funds being used for prevention and early intervention services.

Measure: % Numerator: Amount to be allocated for prevention and early intervention services

Denominator: Total amount of block grant funding minus administrative costs

Source: DMHDD Budget

Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.

Significance: Children and youth under eighteen comprise nearly 25% of Tennessee's population. Early prevention and intervention services are considered most important to avoid more serious emotional and/or behavioral problems.

Name: **Allocation**
Population: **SED Children**
Criterion: **5 (State)**

Fiscal Year	*FY03 Actual*	*FY04 Projected*	*FY05 Target*	*FY05 Actual*	*FY05 Target % Attained*
Performance Indicator	23.6%	23.8%	20%		
Numerator	1,844,400	1,837,000			
Denominator	7,806,700	7,730,700			

DMHDD has targeted both Block Grant and Departmental funding toward services aimed at prevention and early identification of children and youth with behavioral and/or emotional problems. The K-3 program, BASIC, and the Regional Intervention Program (RIP) were developed in Tennessee more than twenty years ago and have expanded across the state. BASIC has been nationally recognized by the American Psychiatric Association and RIP has been extensively researched as a best practice. A number of states seek training from Tennessee to replicate the programs.

While supporting treatment, education, and other child and family support services, DMHDD is committed to the philosophy of prevention and early intervention. Dollars include allocations for BASIC, the Early Childhood Network and suicide prevention.

ABBREVIATIONS GLOSSARY

BADAS	-	Bureau of Alcohol & Drug Abuse Services
BASIC	-	Better Attitudes and Skills In Children
BHO	-	Behavioral Health Organization
BRIDGES	-	Building Recovery of Individual Dreams and Goals through Education and Support
C&Y	-	Children and Youth
CERT	-	Community Emergency Response Team
CHI	-	Creating Homes Initiative
CMHA	-	Community Mental Health Agency
CMHC	-	Community Mental Health Center
CMHS	-	Center for Mental Health Services
CMS	-	Centers for Medicaid and Medicare Services
COD	-	Co-occurring Disorders (Mental Health and Substance Abuse)
COSIG	-	Co-occurrence State Incentive Grant
CRG	-	Clinically Related Groups
CTT	-	Continuous Treatment Team
DCS	-	Department of Children's Services
DDRN	-	Dual Diagnosis Recovery Network
DFA	-	Department of Finance and Administration
DIC	-	Drop-in Center
DMHDD	-	Department of Mental Health and Developmental Disabilities
DOC	-	Department of Correction
DOE	-	Department of Education
DOH	-	Department of Health
DPPC	-	Departmental Planning & Policy Council
DRA	-	Dual Recovery Anonymous
EAP	-	Employee Assistance Program
EBP	-	Evidence Based Practice
EPSDT	-	Early Periodic Screening, Diagnosis, and Treatment
FACT	-	Forensic Assertive Community Treatment
FY	-	Fiscal Year
GAF	-	Global Assessment of Functioning
GED	-	General Education Development
HIV	-	Human Immunodeficiency Virus
HUD	-	Housing and Urban Development
I/P	-	Inpatient
IDEA	-	Individuals with Disabilities Education Act
IMD	-	Institution for Mental Diseases
JOH	-	Journey of Hope
MCO	-	Managed Care Organization
MHA	-	Mental Health Association
MOU	-	Memorandum of Understanding

(Abbreviations Glossary – Continued)

NAMI-TN	-	National Alliance for the Mentally Ill, Tennessee
OMC	-	Office of Managed Care
ORS	-	Office of Recovery Services
PACT	-	Program for Assertive Community Treatment
PASRR	-	Pre-admission Screening and Resident Review
PATH	-	Projects for Assistance in the Transition from Homelessness
RIP	-	Regional Intervention Program
RMHI	-	Regional Mental Health Institute
RMHPC	-	Regional Mental Health Planning Council
SED	-	Serious Emotional Disturbance
SETH	-	Support, Employment, Transportation, and Housing
SMHPPC	-	State Mental Health Planning Council
SMI	-	Serious Mental Illness
SPMI	-	Serious and Persistent Mental Illness
TCPP	-	TennCare Partners Program
TMHCA	-	Tennessee Mental Health Consumers Association
TPG	-	Target Population Group
TSPN	-	Tennessee Suicide Prevention Network
TVC	-	Tennessee Voices for Children